



# Delta Dental Plan of Colorado

Customer Service: 1-800-489-7168

**RETURN TO:**

Delta Dental Plan of Colorado

P.O. Box 173803

Denver, CO 80217-3803

1. PATIENT NAME - PLEASE PRINT FIRST LAST		2. RELATIONSHIP TO EMPLOYEE SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/>		3. SEX M <input type="checkbox"/> F <input type="checkbox"/>		4. PATIENT BIRTHDATE MO DAY YR		5. IF FULL TIME STUDENT, CITY, STATE, SCHOOL NAME	
6. EMPLOYEE NAME FIRST LAST					7. EMPLOYEE SOCIAL SECURITY NUMBER       -       -			8. EMPLOYEE BIRTHDATE MO DAY YR	
9. EMPLOYEE MAILING ADDRESS CITY STATE ZIP					10. NAME OF EMPLOYER State of Colorado				
12. IS PATIENT COVERED BY ANOTHER PLAN? NO <input type="checkbox"/> YES <input type="checkbox"/>			13. IF YES, ATTACH EXPLANATION OF BENEFITS (EOB) NO <input type="checkbox"/> YES <input type="checkbox"/>		11. GROUP NUMBERS (select one only) <input type="checkbox"/> BASIC Plan - 006784 <input type="checkbox"/> BASIC PLUS Plan - 006785				
14. ENTER OTHER FAMILY MEMBER EMPLOYED WITH BENEFIT COVERAGE. OTHER NAME RELATIONSHIP SOC. SEC. NO.					BIRTHDATE MO DAY YR		OTHER DENTAL PLAN NAME		

MY DENTIST MAY GIVE DELTA AND ANY OTHER CARRIER NAMED ABOVE INFORMATION ABOUT MY DENTAL HISTORY, CONDITION OR TREATMENT, AS NEEDED TO DETERMINE BENEFITS RELATED TO THE DENTAL WORK FOR WHICH THIS CLAIM IS MADE. I UNDERSTAND AND AGREE WITH THE TREATMENT RECOMMENDED AND SUBMITTED ON THIS FORM. I CERTIFY THAT THE INFORMATION IN BLOCKS 1 THROUGH 15 IS TRUE AND CORRECT.

**15. SIGNATURE OF PATIENT**

(or parent or guardian)

DATE \_\_\_\_\_

16. DENTIST NAME						24. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?		<input type="checkbox"/>	<input type="checkbox"/>	IF YES, ENTER BRIEF DESCRIPTION AND DATES.		
17. MAILING ADDRESS						25. IS TREATMENT RESULT OF AUTO ACCIDENT?		<input type="checkbox"/>	<input type="checkbox"/>			
CITY				STATE		ZIP		26. OTHER ACCIDENT?		<input type="checkbox"/>	<input type="checkbox"/>	
18. DENTIST SOC. SEC. NO. OR TAX ID NO.			19. DENTIST LICENSE NO. STATE		20. DENTIST PHONE NO. ( )		27. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?		<input type="checkbox"/>	<input type="checkbox"/>	IF NO, REASON FOR REPLACEMENT?	DATE OF PRIOR REPLACEMENT?
21. PREDETERMINATION NO <input type="checkbox"/> YES <input type="checkbox"/>		22. PAR N PAR		23. RADIOGRAPHS OR MODELS ENCLOSED?		NO <input type="checkbox"/>	YES <input type="checkbox"/>	HOW MANY?	28. IS TREATMENT FOR ORTHODONTICS?		<input type="checkbox"/>	<input type="checkbox"/>
									IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED.		MOS. TREATMENT REMAINING.	

[illegible]

It is unlawful to knowingly provide false, incomplete, or misleading facts to Delta Dental Plan of Colorado to defraud or attempt to defraud Delta Dental. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Report any insurance company or agent thereof, who knowingly provides false, incomplete, or misleading facts to Delta participants for the purpose of defrauding the participants regarding their insurance benefits, to the Colorado Division of Insurance.

### ATTENDING DENTIST'S STATEMENT

**COPY AS NEEDED**